BUILDING SCHOOL READINESS THROUGH HOME VISITATION

Prepared for the First 5 California Children and Families Commission
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By

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EXECUTIVE SUMMARY

BUILDING SCHOOL READINESS THROUGH HOME VISITATION

In 2001, the First 5 California Children and Families Commission[a] adopted an overarching criterion by which to judge the success of the California Children and Families First Act: "All young children healthy, learning, and ready to succeed in school."[1] Adapted from the National Education Goals Panel, the Commission defines school readiness as requiring ready children, ready families and communities, and ready schools.

Home visitation is one of the most commonly used service approaches in serving families with young children, reaching as many as 550,000 children and families annually across the nation.[2] At least 37 states have state-based home visiting systems,[3] many as part of school readiness initiatives. Most California counties have elected to use some of their First 5 dollars for home visiting.[4]

Home visiting is being embraced nationally and in California because it has been used to address many goals important for young children and their families, including many of those specified as part of the school readiness definition adopted by the First 5 California Children and Families Commission. (See Table 1) Home visiting is promoted as a strategy that can bring services to socially or geographically isolated families, and through which services can be tailored to meet the needs of individual families.

This paper explores the extent to which research indicates that home visitation can be used as a school readiness strategy. Although there are many different types of home visiting programs, this paper focuses on a subset of home visiting programs – those primary prevention programs that send individuals into the homes of families with pregnant women, newborns, or very young children and seek to improve the lives of the children by encouraging change in the attitudes, knowledge, and/or behaviors of the parents. The following are the main conclusions:

- The popularity of home visiting has been driven by the results of a few studies of programs such as the Nurse-Family Partnership that demonstrate long-term benefits for parents and children.
- Generally, however, results vary widely across program goals, program models, program sites implementing the same model, and families within a single program site.

[a] In Fall 2002, the California Children and Families Commission changed its name to the First 5 California Children and Families Commission.

- Home visiting programs *can* produce benefits associated with school readiness for children and parents, but such benefits are often modest in magnitude, and more often observed among parents and in parent behavior than among children.
- Home visiting programs are most effective in promoting school readiness outcomes when they maintain a clear focus on their goals; are linked with other services, especially those that offer services directly focused on the child; and when the home visiting and associated services are of the highest quality.

Table 1

The Relationship of Home Visiting to the School Readiness Goals of The First 5 California Children and Families Commission

The First 5 California Children and Families Commission specified that school readiness includes three main components (ready children, ready families and communities, and ready schools), each of which is characterized by several attributes. Home visiting programs have been hypothesized to influence the attributes in **bold**.

Children's readiness for school:

- **Physical well-being and motor development**
- **Social and emotional development**
- Approaches to learning
- **Language development**
- **Cognition and general knowledge**

Schools' readiness for children

- **A smooth transition between home and school**
- **Continuity between early care and education programs and elementary grades**
- A student-centered environment focused on helping children learn
- A commitment to the success of every child
- Approaches that have been shown to raise achievement for each student
- A willingness to alter practices and programs if they do not benefit children
- Assuring that their students have access to services and supports in the community

Family and community supports and services that contribute to children's readiness for school success

- Access to high-quality and developmentally appropriate early care and education experiences
- **Access by parents to training and support that allows parents to be their child's first teacher and promotes healthy functioning families**
- **Prenatal care, nutrition, physical activity, and health care that children need to arrive at school with healthy minds and bodies and to maintain mental alertness**

SOURCE: California Children and Families Commission. (2001) *Guidelines and Tools for Completing a School Readiness Application.*

These findings suggest that program planners and funders, including Proposition 10 county commissions, should maintain modest expectations for what home visiting can accomplish, should embed home visiting services in a coherent system of services for families and children, and, above all, should focus on making sure that the home visiting services that are offered in their counties are of the highest quality. Specific recommendations are summarized in Box 1.

Box 1.
Summary of Suggestions for Program Planners

1. Maintain realistic expectations for what home visiting services can accomplish.

2. Make each funded home visiting program a strong, high quality program.

a. Program funders and funding agencies, including county First 5 Commissions should:
   (1) Before launching a program, consider carefully the role that home visiting is likely to play in promoting school readiness.
   (2) Select a program model whose curriculum clearly addresses the goals targeted by the county.
   (3) Consider carefully which agency will administer the proposed home visiting program, and the implications of that choice.
   (4) Support the costs of program monitoring and quality improvement, including data collection, MIS development, data analysis and feedback to program sites.
   (5) Facilitate the development of common definitions among funded programs for key program quality components (e.g., terms such as enrollment, attrition, missed visit, reasons for exit, paraprofessional).
   (6) Require reporting around key program quality components, using common definitions if they have been developed, or asking programs to include their definitions if common definitions are not yet developed.
   (7) Support opportunities for rapid improvement cycles.

b. Individual program sites should:
   (1) Make sure that they adhere to program standards established by the national headquarters for their program model.
      (a) If programs are not affiliated with a national model, then they should make sure that they establish standards for the key components of program quality (e.g., family engagement, curriculum, staffing, cultural consonance, and services tailored to high-risk families).
      (b) If national offices have not yet established such standards, local program planners and funders should urge them to do so, and they should consider seriously selecting another model that has such standards in place.
   (2) Hire, train, and retain the best home visitors available.
   (3) Monitor performance on program standards regularly and provide feedback to staff.
   (4) Seek out opportunities for cross-site comparisons on performance standards, and for follow-up learning to figure out what contributes to the varying performance at each site.
   (5) Within a site, try out rapid improvement cycles, to test strategies to address quality problems.
   (6) Make sure that services are culturally appropriate.

3. **Coordinate home visiting services and resources within each county.**
   a. Before launching a new home visiting program, local First 5 Commissions should sponsor a survey of existing home visiting programs within the county.

   b. Coordinate referrals to home visiting programs.

   c. Coordinate messages across home visiting programs and across other service programs within the community.

   d. Require common definitions and terminology in reports on home visiting services from all agencies and organizations funded with First 5 dollars.

   e. Coordinate the training of home visitors to save resources, build camaraderie, and help programs learn from one another.

4. **Embed home visiting services in a system that employs multiple service strategies, focused both on parents and children.**
   a. To strengthen parenting and promote children's health and development, create a strong system of services that includes health insurance coverage, child-focused child development services, and home visiting.

   b. Include services that are focused both on parents and on children.

   c. Offer multiple approaches for parent-focused services (e.g., both home visits and parent support groups).

   d. Consult with families regularly to make sure that the mix of services is appropriate.

Endnotes

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BUILDING SCHOOL READINESS THROUGH HOME VISITATION

I. INTRODUCTION AND MAIN POINTS

In 2001, the First 5 California Children and Families Commission[b] adopted an overarching criterion by which to judge the success of the California Children and Families First Act: "All young children healthy, learning, and ready to succeed in school."[1] Adapted from the National Education Goals Panel, the Commission defines school readiness as requiring ready children, ready families and communities, and ready schools.

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Home visiting is being embraced nationally and in California because it has been used to address many goals important for young children and their families, including many of those specified as part of the school readiness definition adopted by the First 5 California Children and Families Commission. (See Table 1) Home visiting is promoted as a strategy that can bring services to socially or geographically isolated families, and through which services can be tailored to meet the needs of individual families.

This paper explores the extent to which research indicates that home visitation can be used as a school readiness strategy. Although there are many different types of home visiting programs, this paper focuses on a subset – those primary prevention programs that send individuals into the homes of families with pregnant women, newborns, or very young children and seek to improve the lives of the children by encouraging change in the attitudes, knowledge, and/or behaviors of the parents. The following are the main conclusions:

- The popularity of home visiting has been driven by the results of a few studies of programs such as the Nurse-Family Partnership that demonstrate long-term benefits for parents and children.
- Generally, however, results vary widely across program goals, program models, program sites implementing the same model, and families within a single program site.

[b] In Fall 2002, the California Children and Families Commission changed its name to the First 5 California Children and Families Commission.

- Home visiting programs *can* produce benefits associated with school readiness for children and parents, but such benefits are often modest in magnitude, and more often observed among parents and in parent behavior than among children.
- Home visiting programs are most effective in promoting school readiness outcomes when they maintain a clear focus on their goals; are linked with other services, especially those that offer services directly focused on the child; and when the home visiting and associated services are of the highest quality.

These findings suggest that program planners and funders, including Proposition 10 county commissions, should maintain modest expectations for what home visiting can accomplish, should embed home visiting services in a coherent system of services for families and children, and, above all, should focus on making sure that the home visiting services that are offered in their counties are of the highest quality. Specific recommendations are summarized in Box 1, and explained in greater detail in Suggestions for Program Planners (Section VI).

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SOURCE: California Children and Families Commission. (2001) *Guidelines and Tools for Completing a School Readiness Application.*

This paper describes home visiting programs, including some of the largest national models in the United States (Section II); then summarizes the literature on the effectiveness of home visiting in building school readiness both when home visiting is the primary service strategy (Section III), and also when it is linked with other services (Section IV). Research on the importance of high-quality implementation of services in developing strong home visiting programs is summarized in Section V. All the research findings are distilled into recommendations for program planners and conclusions (Sections VI and VII).

Appendices (A-E) provide extensive detail: Appendix A is the detailed literature review that forms the basis for this paper; Appendix B is an annotated bibliography of the most recent studies, literature reviews, and meta-analyses for readers seeking additional information; Appendix C describes the major home visiting programs in the United States and their presence in California; Appendix D describes some community-wide home visiting efforts in Alameda County, California, and Cuyahoga County, Ohio; and Appendix E contains answers to Frequently Asked Questions (FAQs) often posed by program planners who are considering implementing home visiting.

Box 1.
Summary of Suggestions for Program Planners

1. **Maintain realistic expectations for what home visiting services can accomplish.**

2. **Make each funded home visiting program a strong, high quality program.**

   a. Program funders and funding agencies, including county First 5 Commissions should:
      (1) Before launching a program, consider carefully the role that home visiting is likely to play in promoting school readiness.
      (2) Select a program model whose curriculum clearly addresses the goals targeted by the county.
      (3) Consider carefully which agency will administer the proposed home visiting program, and the implications of that choice.
      (4) Support the costs of program monitoring and quality improvement, including data collection, MIS development, data analysis and feedback to program sites.
      (5) Facilitate the development of common definitions among funded programs for key program quality components (e.g., terms such as enrollment, attrition, missed visit, reasons for exit, paraprofessional).
      (6) Require reporting around key program quality components, using common definitions if they have been developed, or asking programs to include their definitions if common definitions are not yet developed.
      (7) Support opportunities for rapid improvement cycles.

   b. Individual program sites should:
      (1) Make sure that they adhere to program standards established by the national headquarters for their program model.
         (a) If programs are not affiliated with a national model, then they should make sure that they establish standards for the key components of program quality (e.g., family engagement, curriculum, staffing, cultural consonance, and services tailored to high-risk families).
         (b) If national offices have not yet established such standards, local program planners and funders should urge them to do so, and they should consider seriously selecting another model that has such standards in place.
      (2) Hire, train, and retain the best home visitors available.
      (3) Monitor performance on program standards regularly and provide feedback to staff.
      (4) Seek out opportunities for cross-site comparisons on performance standards, and for follow-up learning to figure out what contributes to the varying performance at each site.
      (5) Within a site, try out rapid improvement cycles, to test strategies to address quality problems.
      (6) Make sure that services are culturally appropriate.

3. **Coordinate home visiting services and resources within each county.**
   a. Before launching a new home visiting program, local First 5 Commissions should sponsor a survey of existing home visiting programs within the county.

   b. Coordinate referrals to home visiting programs.

   c. Coordinate messages across home visiting programs and across other service programs within the community.

   d. Require common definitions and terminology in reports on home visiting services from all agencies and organizations funded with First 5 dollars.

   e. Coordinate the training of home visitors to save resources, build camaraderie, and help programs learn from one another.

4. **Embed home visiting services in a system that employs multiple service strategies, focused both on parents and children.**
   a. To strengthen parenting and promote children's health and development, create a strong system of services that includes health insurance coverage, child-focused child development services, and home visiting.

   b. Include services that are focused both on parents and on children.

   c. Offer multiple approaches for parent-focused services (e.g., both home visits and parent support groups).

   d. Consult with families regularly to make sure that the mix of services is appropriate.

II. BACKGROUND

The home visiting programs discussed in this paper are primary prevention programs, beginning prenatally or soon after birth, and continuing for as long as the first 3 or 5 years of the child's life. These programs include nationally known models such as Early Head Start, Healthy Families America (HFA), Home Instruction for Parents of Preschool Youngsters (HIPPY), the Nurse-Family Partnership (NFP), Parents as Teachers (PAT), and the Parent-Child Home Program (PCHP). Together, these programs have thousands of sites across the nation, each has multiple sites in California, and some have inspired the development of home-grown models such as California's Cal-SAHF or ABC programs.

These national models are the home visiting programs whose goals are most closely aligned with the school readiness focus of the California Children and Families Commission, and all have been funded in communities across the country to promote school readiness or children's early learning. Specifically, these programs seek to:

- Promote enhanced parent knowledge, attitudes, or behavior related to childrearing;
- Promote children's health;
- Promote children's early learning and development;
- Prevent child abuse and neglect; and/or
- Enhance mothers' lives (e.g., decrease stress, provide social support, decrease rates of subsequent births and tenure on welfare rolls, and increase employment and education).

Home visiting programs share a reliance on a service delivery strategy (the home visit), but they differ in many ways, including in their goals, intensity of services, staffing, and whom they serve. Table 2 summarizes the basic elements of the largest national home visiting models. (See Appendix C for in-depth descriptions of each program model, profiles of California program sites for each model, and a listing of contact information for California program sites).

The differences among home visiting programs are not trivial. They have important implications for which program models should be selected for use in any community, for the families they are most likely to benefit, and for the likelihood that home visitor and parent will be able to form the close rapport that is the mechanism by which home visiting services work to generate change in parents or children. In other words, communities should select home visiting programs that clearly have the goals they are seeking to address, that have been demonstrated to work well with the families they are seeking to serve, and that employ home visitors who are appropriately trained to serve the families they are seeking to serve. (See Appendix E (FAQ2): What Home Visiting Model Should Be Selected?)

TABLE 2. DESCRIPTIONS OF KEY NATIONAL HOME VISITING PROGRAM MODELS (as of February 2002)

	Program Goals	Onset, Duration, and Frequency of Home Visits	Population Served	Background of Home Visitors	Training Requirements for Home Visitors
Early Head Start 664 sites nationally 53 sites in California	• Promote healthy prenatal outcomes for pregnant women • Enhance the development of very young children • Promote healthy family functioning	For home-based Early Head Start model only: Birth through age 3 Weekly home visits	Low-income pregnant women and families with infants and toddlers; 10% of children may be from families with higher incomes; 10% of program spaces reserved for children with disabilities	No specific requirements, although infant and toddler backgrounds preferred	Vary by program. Staff development plans and ongoing professional development required.
Healthy Families America 450 sites nationally 2 sites in California	• Promote positive parenting • Prevent child abuse and neglect.	Birth through 5th birthday Weekly, fading to quarterly	Parents in the mainland U.S. and Canada, all income levels and ethnicities, who are identified at the time of birth as at-risk for abuse and neglect	Paraprofessionals and Bachelor degrees	One week of pre-service training; 1 day of continuing training quarterly; 80 hours of additional training in the first 6 months of service are recommended by Prevent Child Abuse America.
The Home Instruction Program for Preschool Youngsters (HIPPY) 160 sites nationally 11 sites in California	• Empower parents as primary educators of their children • Foster parent involvement in school and community life • Maximize children's chances for successful early school experiences	Academic year, or two years before, and through the end of kindergarten Bi-weekly, i.e., at least 15 times, over 30 weeks during the school year	Families in the United States and Guam; all ethnicities; many low-income and with limited formal education.	Paraprofessionals, typically members of the community and former HIPPY parents. Most work part-time (20-25 hours/week)	Two-day pre-service training in the HIPPY program model, plus weekly ongoing training and staff development.

	Program goals	Onset and duration	Population served	Background of home visitors	Training requirements for home visitors
The Nurse-Family Partnership 250 sites nationally 11 sites in California (1 to open Fall 2002)	• Improve pregnancy outcomes • Improve child health and development • Improve families' economic self-sufficiency	Prenatal through 2nd birthday Weekly, fading to monthly	Low-income, first time mothers, all ethnicities	Public health nurses	Two weeks of training in the program model over the first year of service. Forty-six hours of continuing education in assessing parent-infant interaction, plus additional continuing education as needed.
The Parent-Child Home Program 132 sites nationally 4 sites in California (1 to open Fall 2002)	• Develop children's language and literacy skills • Empower parents to be their children's first and most important teachers • Prepare children to enter school ready to learn • Enhance parenting skills • Prepare children for long-term academic success and parents to be their children's lifelong academic advocates	Typically 2nd through 4th birthdays, but as young as 16 months (two years total) Two visits/week	Families in the United States, Canada, Bermuda, and the Netherlands; low-income, low-education families; all ethnicities; families with English as a Second Language; teen parents; homeless families	Paid paraprofessionals from the community, many previously parents in the program. Small number of volunteers, who may be professional.	16 hours of training prior to becoming a home visitor. Weekly minimum two-hour ongoing training and supervision session.
Parents As Teachers 2,879 sites nationally 88 sites in California	• Empower parents to give their child the best possible start in life • Give children a solid foundation for school success • Prevent and reduce child abuse • Increase parents' feelings of competence and confidence; • Develop home-school-community partnerships on behalf of children	Prenatal through 3rd birthday; may extend through 5th birthday Monthly, biweekly, or weekly, depending upon family needs and funding levels	Families in the United States and six other countries, all income levels and ethnicities.	Paraprofessionals, and AA, Bachelor, and advanced degrees	One week of pre-service training, 10-20 hours of in-service training, annual credentialing by the Parents As Teachers National Center

Note: By Jan 2003, 51 sites Early Head Start sites and 109 Parents as Teachers sites operated in California.
Source: National program offices and websites for each home visiting model. See Appendix C for additional details, including contact information.

III. DO HOME VISITATION PROGRAMS BUILD SCHOOL READINESS?

Given all the differences across programs, do home visiting programs help produce "ready families and communities," "ready children," and "ready schools?"

The brief answer is, "They can, but they do not always do so." The popularity of home visiting has been propelled by the findings of large and long-term benefits in a few studies (most notably, the studies of the Nurse-Family Partnership). But, in practice, results vary widely across program goals, program models, different sites implementing the same model, and different families within a single site. Further, when benefits are achieved, they are often small in magnitude. Across evaluations of many different home visiting models, the most rigorous studies show that programs are more likely to produce benefits in outcomes related to families (i.e., in aspects of parenting and, perhaps, prevention of child abuse and neglect), than in outcomes related to children (i.e., children's health or cognitive development). Less rigorous, qualitative research suggests that school-based home visiting programs may help parents become more involved with their children's schools in later years. Families that seek out services because their children have been identified as needing extra help, perhaps because they were born low birth weight or with other biological or developmental problems, are more likely to benefit from home visiting services than those families that are offered services primarily because they are socially at-risk (e.g., low income).

Table 3 summarizes the conclusions reached in eight recent meta-analyses (a special kind of literature review) concerning home visiting, and the right-most column in the table summarizes the conclusions reached in this paper. The conclusions in this paper are based on these eight meta-analyses plus additional studies and literature reviews (see Appendices A and B for details).

Table 3 illustrates both the wide-ranging goals that home visiting programs have been designed to address and the wide-ranging conclusions researchers have reached about whether or not the programs have succeeded in reaching their goals. The variability in researcher opinion is related to (1) the studies that they included in their reviews (e.g., international versus only United States programs; family support versus only home visiting programs; home visiting plus other services or only home visiting services; programs serving families with children with identified biological problems versus families whose only risk factor is low income); and (2) the willingness of the researchers to draw conclusions from sometimes small numbers of studies.

Despite the variability in researcher conclusions, however, Table 3 illustrates three important points:

- Evaluators have assessed the effectiveness of home visiting in promoting change in at least 14 broad categories of outcomes, each of which can be related to the school readiness definition adopted by the First 5 California Children and Families Commission.

Table 3.
Summary of Meta-Analyses and Overall Conclusions about the Effects of Home Visiting

	Abt Associates (Short-Term)[5]	Abt Associates (Follow-Up)[5]	Appelbaum & Sweet[6]	Elkan et al[7]	Roberts et al[8]	Guterman[9]	MacLeod & Nelson[10]	Hodnett[11]	CONCLUSIONS
READY FAMILIES AND COMMUNITIES									
Parenting Knowledge/Attitudes/ Behavior (HOME)	.18/.25/.30	-/.18/ -	.10	+		+			+
Child Health and Safety									
Nutrition: Breastfeeding/Diet				+/?					-
Preventive Health Services & Medical Home				-					-
Child Health Status									
Birth Outcomes: Preterm Birth and LBW								-	-
Child Health Status and Physical Growth	.09	-		-					-
Child Safety	.15	-							
Home Safety Hazards									
Unintentional Injuries				+					
Child Abuse and Neglect			.17-.48	?	?		.41		+
Maternal Life Course									
Stress, Social Support, Mental Health	.09	.17	-	+/?					-
Economic Self-Sufficiency	.10	.39	-	?					?
Education			.11	?					?
READY CHILDREN									
Children's Cognitive and Language Development, Academic Achievement	.09/.26/.36*	.30		+					-
Social and Emotional Development, Child Behavior	.15	.09		+					?
READY SCHOOLS									
Parental Involvement with Children's Education/School Events									?

Notes: + indicates positive effect shown; - indicates no effect; ? indicates not enough adequate studies to draw a conclusion.
Numerical values are in standard deviation units. Variation across meta-analyses driven by the studies included. Abt Associates: U.S. only; family support (not just home visiting) programs, unless otherwise noted. Hodnett: broad-based social support. Elkan et al, Roberts et al, MacLeod & Nelson, and Hodnett: home visiting only, but include international studies. Elkan et al and Abt Associates (except where otherwise noted) include children with special needs.
* Only home visiting programs: .09=untargeted population; .26=both special needs and other children; .36=targeted to children with special needs only. See also Appendices A and B for details about and key findings from each meta-analysis.

- On average, home visiting programs have rarely produced effects exceeding .20 of a standard deviation in size – a magnitude of effect that is considered small in the human services arena. This means that home visiting programs will rarely produce large, easily-observed changes across most of the families they serve. Change will be especially difficult to detect if small numbers of families are being served in any one program or if the measures used to detect change are not very sensitive. Program planners should therefore moderate their expectations about just how much change any home visiting program can produce.

- Home visiting may be more effective at producing some outcomes than others.

The following sections summarize the research findings, organized by the three major outcome areas mentioned in the school readiness definition adopted by the First 5 California Children and Families Commission: (1) Ready Families and Communities; (2) Ready Children; and (3) Ready Schools.

A. Ready Families and Communities

Some of the strongest benefits of home visiting are found in outcomes related to Ready Families and Communities. As defined by the First 5 California Children and Families Commission, this area includes parenting, child maltreatment, changes in the home environment, child health and safety, and maternal self-sufficiency. It is in the parenting and child maltreatment areas that home visiting programs may have their strongest effects.

1. Parenting

The most consistent benefits of home visiting programs are found in domains related to parenting such as parent attitudes, knowledge about child development, or parenting behavior, rather than in areas such as child development, child health, or maternal economic self-sufficiency.

The parents who show the greatest improvement in parenting behavior are those who entered the home visiting program because their children were identified as having behavior problems.[5] These parents may benefit most because they may have sought out services to help address specific problems, and they may therefore be especially motivated to change their own behavior. Of course, most of the home visiting programs that have been promoted to build school readiness do not recruit families with already-identified problems, but rather seek to support families before problems develop. Those primary prevention home visiting programs may therefore face a heavy burden to generate change because parents may not yet see any reason to change their parenting behavior.

2. Child maltreatment

Some programs are associated with changes in parent-child interaction or the prevention of child abuse and neglect, depending upon how these changes are measured. Changes are more likely to be detected in paper-and-pencil tests of parents attitudes

toward discipline or in the rates of usage of the emergency room for injuries and ingestions than in confirmed rates of child abuse and neglect, for example. Nevertheless, the areas of parenting and the prevention of child maltreatment are probably where home visiting programs have their strongest effects.

On the strength of these results, organizations such as the United States General Accounting Office[12], the U.S. Advisory Board on Child Abuse and Neglect[13], the American Academy of Pediatrics[14], the Association of Maternal and Child Health Programs[15], the Centers for Disease Control and Prevention (CDC)[16], the Office of Juvenile Justice and Delinquency Prevention[17], the National Academy of Sciences[18], and the National Governors Association[19], and have all endorsed the use of home visiting to prevent child maltreatment. In conjunction with the CDC, the Task Force on Community Preventive Services has concluded that up to 40% of all child maltreatment could be prevented if home visiting were widely available.[20]

The 40% estimate may be high because studies suggest that home visiting programs are not equally effective with all families. Different research teams have concluded that the programs that are the most effective in preventing child abuse and neglect are those that (1) serve mothers who have low coping skills; [21] and (2) serve families with relatively few episodes of domestic violence;[22] or are those that (1) serve families with children under age 3; (2) provide case management services; (3) serve teen parents; and (4) provide parent-child activities.[5]

3. Home environment

Changes in the home environment – either to make it safer or more likely to promote early literacy or child development – occur, but they are more rare than change in parenting attitudes or parent knowledge about child development.

4. Child health

Many home visiting programs (notably, many sites of the Healthy Families America program) have demonstrated that the families enrolled in their services achieve very high rates of immunizations or connections with a medical home.[23] Limited evidence suggests that home visiting programs may be helpful in promoting breastfeeding.[7] When tested with rigorous methods that compare home-visited families with randomly assigned control groups in the community, however, most home visiting programs have not increased the utilization of preventive health care, or improved children's diets (with the exception of breastfeeding), health status, or physical growth. The major determinant of children's utilization of health care is probably the availability of health care services within the community, which is driven by factors such as the availability of health insurance or transportation to health care clinics rather than the presence or absence of a home visiting program.

5. Maternal self-sufficiency

When tested with rigorous methods, most home visiting programs have not improved mothers' self-sufficiency (e.g., increased education, employment or income; deferred second pregnancies; decreased stress or mental health problems), but there is tantalizing

evidence from at least one home visiting program that home visiting can improve mothers' lives.

The Nurse-Family Partnership (NFP) is one of the few home visiting programs with a long-term follow-up. In Elmira, New York, over the course of 15 years after the birth of their children, poor unmarried women who had been home-visited had fewer subsequent pregnancies and births, were more likely to delay a second birth, spent fewer months on welfare or receiving food stamps, and had fewer problems due to substance abuse and fewer arrests than their counterparts in the control group. These were large differences: 60 versus 90 months on welfare, for example, and 65 versus 37 months between first and second births,[21] and a 1998 RAND Corporation study concluded that the program returned 4:1 savings to government, when it was offered to a high-risk population.[24]

But, in Memphis, the second NFP site, while subsequent pregnancies were deferred, they were not postponed as long as they had been in Elmira (a 67% reduction in Elmira versus 23% in Memphis at the end of program services), and there were no differences in employment or receipt of AFDC.[21] Follow-up is continuing to determine whether increased benefits will be observed in Memphis over time as they were in Elmira.

Few other programs have assessed economic self-sufficiency of the mothers, but, of those that have, many have found no benefits, or much smaller benefits. For that reason, no firm conclusions are drawn about the benefits of home visiting in this area.

B. Ready Children

Children's cognitive, language, and social and emotional development are all part of the definition of Ready Children. Home visiting programs may not be as effective in promoting clear changes in children as they are in helping change behavior of parents.

1. Cognitive child development

Some studies of programs such as Parents as Teachers,[25] HIPPY,[26] or the Parent-Child Home Program[27] have demonstrated that home visited-children out-perform other children in the community through the 4th, 6th, or 12th grades on measures such as school grades and achievement test scores on reading and math, suspensions, or high school graduation rates. However, large cognitive benefits such as these are *not* demonstrated reliably in randomized trials of home visiting programs.

In most studies, some subgroups of children do benefit, but the subgroups are not consistent across studies or across different sites of the same program model. For example, in an evaluation of HIPPY, children's cognitive development, school achievement, and classroom adaptation were assessed for two cohorts of children at each of two program sites and at two points in time. No clear pattern of results emerged: children in the first cohort benefited on some measures at one site but not at the other, or at one point in time but not at the other, and children in the second cohort did not benefit at either site.[28] Similarly mixed results can be found for many other home visiting programs.

Home visiting programs that serve socially at-risk (e.g., low income populations) generate small cognitive benefits of about .09 of a standard deviation; but programs that serve both biologically at-risk (e.g., child born low birth weight or with special physical needs) and socially at-risk children produce cognitive benefits that are about 3 times larger; and programs that serve only children with special needs produce benefits that are about 4 times larger.[5] In other words, as was the case concerning parenting behavior, cognitive benefits are largest when parents enroll in services because their child has a clear need for extra intervention. The larger benefits may reflect enhanced parental motivation to change their own behavior and to encourage change in their children, or it may reflect that change is easiest to produce and detect among those children who have the greatest distance to improve.

2. Social development

Social development benefits are elusive, although the NFP has found significant long-term benefits in children's behavior 13 years after services ended in Elmira, New York, when the children were 15 years of age. Benefits included fewer instances of running away, arrests, convictions, cigarettes smoked per day, and days having consumed alcohol in the last six months, less lifetime promiscuity, and fewer parental reports that children had problems related to drug or alcohol use.[21] Only a few other home visiting programs have followed families over time; and short-term social development benefits are rarely observed among children.

C. Ready Schools

Little research has examined the linkages between schools and home visiting programs, but many PAT, PCHP, and HIPPY programs are administered through school districts, and two descriptive studies of PAT and HIPPY suggest that home visiting linked with schools may result in parents becoming more involved in their children's schools, as evidenced by their attendance at special events in the school, work as school volunteers, participation in PTA meetings, communication with teachers, and assistance with homework.[29,30] This under-studied area may be a fruitful one to explore in future evaluations.

IV. DELIVERING HOME VISITS IN COMBINATION WITH OTHER SERVICES

The very mixed results reported above are derived from studies of programs in which home visiting was the primary service strategy. Would benefits be larger if home visiting were combined with other service strategies?

For child development and especially cognitive development outcomes, the answer is a clear "yes." Over the past 30 years, the early childhood programs that have produced the most substantial long-term outcomes for children were those that combined center-based early education services for children with significant parent involvement through

home visiting, joint parent-child activities, parent groups, or some other means.[31] In these programs, children demonstrated benefits in academic achievement throughout their school years, and were more productive citizens (committed fewer crimes and displayed less delinquent behavior, for example) as young adults. Similarly, interim results for Early Head Start[32] demonstrate that the children in Early Head Start program sites where both home visits and center-based services were offered achieved larger and broader cognitive and language development benefits than children in sites which offered only center-based or only home visiting services.[c] Researchers from Abt Associates[5] have quantified this difference: Family support programs with home visiting services produce gains in cognitive development of .26 of a standard deviation in magnitude, but programs with early childhood education components generate effects almost twice as large (.48).[d]

The National Academy of Sciences concluded, "Programs that combine child-focused educational activities with explicit attention to parent-child interaction patterns and relationship building appear to have the greatest impacts."[33] In other words, parent involvement contributes a unique advantage in center-based early childhood programs.

But, just as important, the conclusion of the National Academy of Sciences suggests that home visiting programs must be coupled with child-focused programs like a good quality child care or preschool program to produce the longest-lasting, broadest range, and largest magnitude changes in children. If that is not possible, perhaps because center-based child care programs are not present in a low-income area or a far-flung rural community, then the home visiting program itself should include extensive, direct, child-focused activities during the home visits in order to promote child development.

V. THE DRIVE FOR QUALITY

Across all the mixed study results, there is one consistent finding: Every home visiting program struggles to deliver high quality services to families. Benefits for children and parents would be stronger and more consistent if program quality were enhanced. Indeed, the National Academy of Sciences has concluded that the key to program effectiveness is "likely to be found in the quality of program implementation…."[34]

Efforts to improve program quality should focus on family engagement, curriculum, home visitors, cultural consonance between program and families served, and delivering appropriate services to high-risk families.

A. Family Engagement

Family engagement encompasses four primary elements: The ability of the program to (1) enroll families, (2) deliver services at the intended level of intensity, (3) retain

[c] These differences fade somewhat in the final, year 3 evaluation results. See Appendix B.
[d] These effect sizes are for programs serving children with and without special needs. As reported in Table 3, the effect sizes are smaller when programs that served children without special needs are excluded.

families in the program, and (4) maintain enthusiastic and active family involvement during home visits and in recommended activities between visits.

Too often, families receive a watered-down version of home visiting services.[2] Up to 40% of families that are invited to enroll in home visiting programs choose not to participate. Acceptance rates are highest (94-98%) in programs that offer a single home visit to all families with newborns or all first-time or teen mothers in a community. Once enrolled, between 20% and 80% of families leave home visiting programs before services are scheduled to end, with typical attrition rates hovering at about 50%. Families who remain in the program typically receive about half the scheduled number of home visits. And, between visits, families do not always do the "homework" that has been assigned to them – and upon which the benefits for children depend. For example, families must read to their children between visits, employ new forms of discipline, or follow up with referrals to other services systems if the hoped-for benefits are to emerge – but research indicates that parents do not always follow the recommendations of their home visitor to change their behavior.

B. The Curriculum

Evidence suggests that benefits are most likely to occur in those program areas that have been emphasized by home visitors in their interactions with families. It is important, therefore, that program planners select a curriculum that directly addresses the goals that have been established for the home visiting program. (See Box 2 for information about selecting curricula.)

Box 2.
Selecting a Home Visiting Curriculum

Program planners should select a curriculum for their home visiting program that directly addresses the goals they have established for the program. National home visiting programs such as PAT, HIPPY, NFP, and PCHP provide a curriculum, but other national programs allow greater flexibility. And, of course, many home visiting programs are developed locally, with program planners often seeking to develop their own curriculum or adopt an existing curriculum.

Researchers from the Center for Prevention & Early Intervention Policy at Florida State University have reviewed curricula for programs that serve expectant families and their infants. Their summary includes information about the intended audience and age range, availability of materials in languages other than English, topics covered, reading level and ease of use, evidence of effectiveness, availability of training and support, and cost.

Graham, M., Chiricos, C., White, B., Clarke, C., et al. Choosing curricula for quality programs serving expectant families & their infants. Florida State University.

But, home visitors can vary greatly in their delivery of the home visit – addressing different content, staying in the home for differing lengths of time – even if they are all trained to deliver the same model. Programs must therefore both (1) employ curricula that clearly address the behaviors associated with a poor outcome (e.g., smoking cessation

during pregnancy to prevent low birth weight; the presence of domestic violence to prevent child maltreatment); and (2) deliver those curricula as intended by the program designers.

C. The Skills and Abilities of the Home Visitors

The success of a home visiting program rides on the shoulders of its home visitors. From the point of view of families, home visitors *are* the program. They draw families to the program, and they deliver the curriculum. Home visitors must have the personal skills to establish rapport with families, the organizational skills to deliver the home visiting curriculum while still responding to family crises that may arise, the problem-solving skills to be able to address issues that families present in the moment when they are presented, and the cognitive skills to do the paperwork that is required. These are not minimal skills, and there is no substitute for them if programs are to be successful.

Hiring the right home visitor is therefore crucial for program success. Unfortunately, research can provide only limited advice on who makes the best home visitors, and most researchers believe it is not possible at this time to conclude that individuals from a particular professional or educational discipline are better home visitors than others.[35,36] However, many of the most recent studies of programs that employed paraprofessionals produced either no or only very modest results,[37,38] and a recent study of the NFP in Denver, Colorado, which directly compared the effectiveness of nurse and paraprofessional home visitors, indicated that paraprofessionals produced benefits of only about half the magnitude of those produced by nurses in outcomes such as deferral of second pregnancies, maternal employment in the second year of the child's life, and mother-infant interaction.[39] (See Appendix B for more details of this study.)

The best advice is to keep in mind the program's goals, the families being served, and the curriculum when choosing a home visitor. Extremely well-trained visitors who are at least high school graduates and have experience in early childhood or the helping professions are probably needed to serve families who are facing multiple, complex issues; or to work in programs with multiple, broad goals or with a curriculum that allows a great deal of flexibility.[36] Paraprofessionals may do best in programs with a relatively proscriptive curriculum, where lesson plans are detailed and clear. (See Box 3 for resources on training materials for home visitors.)

Once they have hired their home visitors, programs must work hard to retain them. Turnover can have a devastating effect on program success rates because it disrupts the rapport and connection between home visitor and parent, and it is that rapport which makes parents more likely to follow the advice of their home visitors. In the NFP in Memphis, for example, turnover among nurses was 50%, and the evaluators suggest that this may be at least part of the reason that results were more limited in Memphis than in Elmira.[21]

Turnover may be a special problem in programs using lower-paid paraprofessionals for whom home visiting may be their first job. HFA and ABC/Cal-SAHF programs in

San Diego and Sacramento have reported turnover rates of about 70% over 18-36 months;[37,40] (See Appendices B and C, respectively, for descriptions of these programs.) A survey of home visiting programs in San Mateo County confirms that turnover is especially an issue among paraprofessional home visitors,[41] and there is some evidence from the Early Head Start program evaluation that low wages, averaging $9.77 per hour in that program, contribute to staff unhappiness.[42]

Box 3. Training Home Visitors

Most of the large home visiting models have prescribed training courses for program coordinators, supervisors, and home visitors. However, communities should consider launching joint training opportunities for home visitors. Barbara Wasik, a professor at the University of North Carolina, Chapel Hill, recommends that all home visitors receive training that covers basic concepts such as the history and philosophy of home visiting, knowledge and skills of the helping process, knowledge of families and children, and knowledge of the community – in addition to the knowledge and skills specific to the particular home visiting program they are delivering. She and her colleagues have catalogued training materials for home visitors. Some of these catalogued materials also include curricula for home visiting programs.

Wasik, B.H. (1993) Staffing issues for home visiting programs. *The Future of Children*, 3(3), 140-157. www.futureofchildren.org

Wasik, B.H., Shaeffer, L., Pohlman, C., & Baird, T. (1996). A guide to written training materials for home visitors. Chapel Hill: The Center for Home Visiting, University of North Carolina at Chapel Hill. www.unc.edu/~uncchv

Wasik, B.H., Thompson, E.A., Shaeffer, L., & Herrmann, S. (1996). A guide to audiovisual training materials for home visitors. Chapel Hill: The Center for Home Visiting, University of North Carolina at Chapel Hill. www.unc.edu/~uncchv

Programs should seek to support home visitors through excellent supervision, a good working environment, and supportive training. A good supervisor is especially important because a good supervisor can help home visitors deal with the emotional stresses of the job, maintain objectivity, prevent drift from program protocols, provide an opportunity for reflection and professional growth, and model the relationship that the home visitor should establish with the parent.[35] Home visiting can be a lonely job, and visitors in small programs may work largely on their own, sometimes without anyone to turn to when problems arise. The best programs build in enough time for the supervisor to meet regularly with the home visitors and to accompany them on occasional visits to families.

D. Cultural Consonance Between the Program and Its Clientele

Parenting practices are strongly bound by culture. Parents of different cultures possess strongly held beliefs about the best approaches to handling sleeping, crying, breastfeeding,[43] discipline,[36] early literacy skills,[44] and obedience and autonomy in children.[36] Further, it appears that the same parenting practices can yield different results for children from different cultures. For example, one recent review suggests that although an authori*tative* parenting style may be associated with more positive outcomes

for white children, a stricter, authori*tarian* style may be associated with more positive outcomes for African-American and Asian-American children.[36]

These differences in parenting practices across cultures may render home visiting programs less effective with some families – if the advice offered by the home visitors is not consonant with the family's beliefs about parenting. In one study, some African-American and Latina mothers characterized home visitor advice as "white people stuff" and ignored it. In the same study, white working class families sometimes questioned home visitors' advice regarding parenting practices, including reading daily to infants.[45]

These different beliefs may be especially important in families in which mothers live with their mothers or extended family. In those families, even if the mother is persuaded that she ought to change an aspect of her behavior, she must also persuade her relatives. Such change can cause strife within the family,[43] and, therefore, some interventions seek to involve grandparents, fathers, or other family members.[46,47] Early Head Start programs, for example, employ a variety of strategies to engage fathers, as described in Box 4.

Box 4.
Strategies to Engage Fathers in Early Head Start

Most home visiting programs focus their services on mothers. But, in many cultures, involvement by fathers and/or by extended family members is critical if programs are to succeed.

Among the 17 Early Head Start (EHS) sites participating in a national evaluation, about 25% had implemented services to involve fathers within the first few years of the program's initiation. The evaluators noted that the programs, "encouraged fathers to participate in regular program services, had staff responsible for working with and involving fathers, offered male support groups, provided recreational activities for men, used a special curriculum for males, or provided other services for males."

By the end of the evaluation, when children were 3 years of age, EHS fathers were more likely to participate in child development activities such as home visits or parenting classes than control fathers, and were less likely to report spanking their children during the previous week (25.4% vs. 35.6%) and were less obtrusive. Their children were more able to engage them during play than were children of control group fathers.

Source: Love, J.M., Kisker, E.E., Ross, C.M., Schochet, P.Z. et al. (June 2001). *Building their futures: How Early Head Start programs are enhancing the lives of infants and toddlers in low-income families.* Vol. 1. Technical report. Department of Health and Human Services, Washington, DC. Available at http://www.acf.dhhs.gov/programs/core/ongoing_research/ehs/ehs_intro.html

Love, J.M., Kisker, E.E., Ross, C.M., Schochet, P.Z., et al. (June 2002). *Making a difference in the lives of infants and toddlers and their families: The impacts of Early Head Start. Executive Summary*. Department of Health and Human Services, Washington, DC. Available at http://www.acf.dhhs.gov/programs/core/ongoing_research/ehs/ehs_intro.html

There is no clear evidence as to which groups benefit most. For example, in a Salinas Valley PAT project, children of Latina mothers benefited more than other groups on child development outcomes.[48] In interim results for Early Head Start, however, African-American children benefited most, with very few benefits for Hispanics,[49] although both

groups benefited more than white families by the time the study ended.[50] In San Diego's HFA program, white but not African-American or Hispanic women deferred second pregnancies.[37]

The National Academy of Sciences concludes that "…parenting interventions that respond to cultural differences in a dismissive or pejorative manner are likely to precipitate significant conflict or be rejected as unacceptable."[51] This may contribute to high attrition rates.

Because families may withdraw when they hear advice with which they disagree, home visitors may be tempted to refrain from broaching those touchy topics where they know that the program recommends an approach other than the one embraced by the culture of the families they are visiting. While steering clear of controversy may keep families in the program longer, tenure in a program by itself will not lead to benefits for parents or their children. The key is to keep a focus on the specific goals of the program, and to make sure that home visitors find ways to return to that advice, relying upon their relationship with the families to help persuade parents to change their behavior.

The issue of cultural consonance is especially important in multicultural California. All the large home visiting program models have been employed to serve families from many cultures. The California programs profiled in Appendix C, for example, serve white, African-American, Hispanic, Asian American, and Native American families, and immigrants from many nations. Nevertheless, research has yet to catch up with the diversity that is part of the fabric of life in the state, and, while there have been several studies of home visiting with white, African-American, and, to a lesser extent, Hispanic families, there have been far fewer with Asian-Americans or other groups.

Despite the sparse research, programs should institute some minimum standards: While ethnic and racial matching of home visitors to families may not be necessary,[35] home visitors should speak the language of the families they are visiting and should understand their culture, and, especially, their beliefs about parenting, health practices, and the roles of women. To the extent possible, home visitors should involve members of the extended families of the mothers they visit.

E. Developing Services Appropriate for High-Risk Families

As home visiting programs extend their outreach to families at higher levels of risk, they face increasing challenges in developing curricula that can address the needs of those families. For example, HFA uses a screening tool to select higher-need families; NFP only enrolls low-income, first-time pregnant women; and programs drawing their clientele from TANF rolls may find that more and more women have higher levels of need as most women with fewer needs have already entered the workforce. For most programs, therefore, quality services require having curricula and staff in place to serve a high-risk population.

Home visiting programs should be prepared to address three issues which can create especially high risk for children: (1) domestic violence in families; (2) maternal mental health problems, especially depression; and (3) parental substance abuse. Results from many home visiting programs suggest that these issues are among the hardest for home visitors to recognize or to address effectively, and, along with contraception, are the issues that they feel least comfortable discussing.[37,40,52] But, these are precisely the issues that are most likely to stymie progress for parents and to harm children.

For example, about 20% of the general population, as many as 30-40% of the welfare population,[53] and up to 50% of families in some home visiting programs have symptoms of clinical depression.[37,40,52] Every woman enrolled in the HFA program in Lancaster, California had mental health issues upon initial screening.(See Appendix C-2.) Fully 16% of the caseload in an HFA program in Oregon experienced domestic violence just within the first 6 months after enrollment,[54] and 48% of the families experienced domestic violence in the Elmira, New York site of the NFP over a period of 15 years.[22] In the Oregon HFA program, families that experienced domestic violence within the first 6 months of their children's lives were three times more likely to have physical child abuse confirmed than families without domestic violence during that six-month window.[54] Home visiting services must be modified to respond to domestic violence and these other issues. These are sentinel events that have substantial impact on children over the long run.

F. The Malleability of Quality

There is heartening evidence that program quality can be monitored, shaped, and improved. For example, when Healthy Start program administrators in Hawaii discovered that attrition rates varied from 38% to 64% across home visiting agencies, they developed program performance guidelines to govern the time from enrollment to first home visit, home visit frequency, and program attrition. A quick feedback loop in which data on program performance is fed back to program managers is one mechanism by which these variations can begin to be understood and controlled. The Sacramento County Birth and Beyond program has used data in this way, and the NFP has a system in place by which program sites send information to the national offices that then flag for technical assistance those sites where performance is falling below quality thresholds. (See Appendix C-7 and Box 5, respectively.)

When quality improves, outcomes for children improve, too. Early Head Start sites that had early, full implementation of the program's performance standards generated greater benefits in children's development than did sites which had not yet met the standards.[49] In Hawaii's Healthy Start program, program sites that delivered services with the greatest fidelity to the model had the greatest effect on mothers' mental health.[55]

Box 5.
Quality Assurance Strategies in The Nurse-Family Partnership

The Nurse-Family Partnership has a quality assurance system in place that incorporates many of the recommendations listed above. The NFP has specific standards for program performance and requires its program sites to send their performance data to the national office. The national office then reports back to sites to allow them to compare their performance against that of other sites, and against that of sites in which earlier randomized trials indicated significant benefits for children and families. When sites fall below performance benchmarks, the national office offers technical assistance to troubleshoot and problem-solve.

Performance standards in the NFP are based on performance levels observed in program sites, such as Denver, where benefits were observed in children and parents. So, if programs deliver services at levels similar to those achieved in Denver, it is assumed that the programs will also be able to deliver commensurate benefits for children and families.

VI. SUGGESTIONS FOR PROGRAM PLANNERS

The research suggests that home visiting services can play an important role in school readiness efforts, but program planners should maintain realistic expectations about the benefits that home visiting services can produce. The design of home visiting programs should be considered carefully before they are implemented; they should be supported as one of a range of community services for families and young children; considerable effort should be devoted to maintaining program quality and using evaluation data; and individual programs should be coordinated with one another and with other services within their county.

The following are suggestions to local County Commissioners, and to national and local program planners and policymakers who are considering home visiting:

1. Maintain realistic expectations for what home visiting services can accomplish.

Home visiting programs are interventions that have been given large mandates – prevent child abuse; promote school readiness; move families from welfare to work; and more – but no single program is likely to be able to accomplish all those goals. Program planners must maintain realistic expectations for what any single intervention can achieve.

In addition, program planners should be clear about the expectations they have for universal versus targeted home visits, and for limited duration versus intensive home visiting. Most of the research reviewed in this paper focuses on home visiting programs that sought to deliver fairly long-term services to families. Communities such as Alameda County and Cuyahoga County in Ohio, however, have begun to offer an initial home visit to most or all families within their community, no matter the income level of the families (see Appendix D). These visits tend to be extremely popular and well-received. In Cuyahoga County, they result in as many as 25% of

the visited families being referred on to additional services. But, the long-term effectiveness of these widely-offered services in either identifying families earlier, engaging them more closely with service systems, or promoting their children's school readiness has not yet been demonstrated. (See Appendix E (FAQ7): Should We Target Services to Particular Groups or Offer Them Universally?)

2. Make each funded home visiting program a strong, high quality program.

Program planners and administrators, and individual program sites should take steps to ensure quality services.

a. Program funders and funding agencies, including local First Five Commissions should:

(1) Before launching a program, consider carefully the role that home visiting is likely to play in promoting school readiness.

There are many service strategies available to promote various aspects of school readiness. Before endorsing home visiting, local funders should consider the specific goals that they hope the proposed home visiting program will accomplish, and the community context. If they are especially interested in cognitive development, for example, they might consider a center-based, child-focused service strategy instead of or in addition to home visiting. If their community is a far-flung rural area, or one in which most families prefer informal child care, then center-based programs may not be feasible, and home visiting can be considered as a strategy to promote cognitive development, so long as it has a strong, child-focused component. (See Appendix E (FAQ1): Should We Launch A Home Visiting Program to Promote School Readiness?)

(2) Select a program model whose curriculum clearly addresses the goals targeted by the county.

Research indicates that programs typically can only accomplish those goals on which their home visitors focus, and so it is important to select a program whose goals and curriculum match the goals of the community. Some programs (e.g., HIPPY, PAT, and PCHP) may focus most on child development and early literacy activities. Others (e.g., HFA) may focus most on the prevention of child abuse and neglect and the promotion of good parenting. Some programs (e.g., NFP, HFA, and EHS) include explicit attention to family economic self-sufficiency, whereas others refer families to other community services for assistance in those arenas.

Having a deep understanding of the curriculum is especially important when choosing among home visiting programs that have multiple goals (as almost all do). Because home visitors usually are able to complete only

about half their visits, it is important to understand which parts of the curriculum are considered to be of core importance to the program, because those are the messages that will be most likely to be conveyed to families. (See Appendix E (FAQ2): Which Home Visiting Model Should Be Selected?)

(3) Consider carefully which agency will administer the proposed home visiting program.

Administering agencies possess philosophies about what families need and how they should be served, and they bring their history in the community, familiarity with particular content areas and the staff associated with those areas, and, in some cases, complementary services. All of these can affect the content and services that families eventually receive during the home visit and between visits. For example, the same program delivered by a home visitor who is a social worker will have a different slant when it is delivered by an individual with an early childhood background. The Birth & Beyond home visiting program in Sacramento reports that families may be more likely to welcome home visits from agencies that have a long history in the community. Different administering agencies may have, as they did in Hawaii's Healthy Start program, different philosophies about how hard to work to try to engage families – which may influence attrition from the program. A recent evaluation of PAT suggested that families benefited most when home visits were delivered by an agency with a rich array of complementary services which families could access easily. These should all be considerations of funders before they support the expansion of home visiting services. (See Appendix E (FAQ3): Does Who Administers the Program Make a Difference?)

(4) Support the costs of program monitoring and quality improvement, including data collection, MIS development, data analysis and feedback to program sites.

Typical home visiting programs cost between $1,500 - $5,000 per family per year. Fully 80% of the program costs are direct costs for personnel. While program monitoring and quality improvement costs may not encompass a large percentage of the budget, an attention to quality and a commitment to paying for the tools that are necessary to maintain quality are imperative if home visiting services are to benefit families. (See Appendix E (FAQ8): How Much Does Home Visiting Cost, and How Can We Pay for Services?)

(5) Facilitate the development of common definitions for key program quality components (e.g., terms such as enrollment, attrition, missed visit, reasons for exit, paraprofessional) among funded programs.

Different program models, and sometimes different sites of the same program model, employ different definitions of important terms. For example, some programs define a family as enrolled when the mother first gives her consent to participate in a home visiting program. Others say the family is enrolled after the first home visit is completed, after the first three visits are completed, or after the Individual Family Service Plan is completed. Similar variability occurs in the definition of attrition. Clearly, these differing definitions can create very different pictures of the performance levels in any one program. Funders can facilitate the process of developing clear, common definitions that can be used by all home visiting programs in their community.

(6) Require reporting around key program quality components, using common definitions if they have been developed, or asking programs to include their definitions if common definitions are not yet developed.

(7) Support the use of techniques of continuous quality improvement similar to those used in business. Support rapid improvement cycles, in which new strategies to address quality problems are tried out for a few months, data are collected to monitor their effects, and, if successful, the new approaches are implemented. If the strategies are not successful, then other approaches are tried. These might include new strategies to retain families, new approaches to recruiting families to the program, new training for program staff to focus on particular aspects of the curriculum, and so on.

b. Individual program sites should:

(1) Make sure that they adhere to program standards established by the national headquarters for their program model.

If programs are not affiliated with a national model, then they should make sure that they establish standards for the key components of program quality. The performance standards should address issues of engagement (including enrollment, service frequency, attrition rates, and involvement of families in complementary services such as parent group meetings); staff background, training, caseloads, and supervision levels; cultural consonance; and addressing families with special needs. Developing clear definitions for terms related to engagement are especially important because these terms are used very differently across models and program sites.

If national offices have not yet established performance standards, local program planners and funders should urge them to do so, and they should consider seriously selecting another model that has such standards in place.

(2) Hire, train, and retain the best home visitors available.

Home visitors are the keys to program effectiveness. Programs should work to hire, train, and support the best home visitors they can find. In their

relationships with home visitors, site managers should model the relationships that home visitors should establish with the families they serve. Home visitors should receive training about home visiting in general as well as about the specific model of home visiting that they are being hired to deliver. And, special efforts should be devoted to making sure that home visitors understand, endorse, and are able to implement the specific home visiting curriculum associated with the selected model. Just as the families they visit have views about parenting which they bring to any home visit, so too do home visitors, and it is imperative that the visitors understand and believe in the goals of the program that they are being hired to implement – including views about discipline, family planning (if that is part of the program), and other sensitive family matters. (See Appendix E (FAQ6): Whom Should We Hire as Home Visitors?)

(3) Monitor performance on program standards regularly and provide feedback to staff.

(4) Seek out opportunities for cross-site comparisons on performance standards, and for follow-up learning to figure out what contributes to the varying performance at each site. Table 4 in Appendix A summarizes the attrition rates from recent studies of several home visiting programs. A similar comparative chart could be developed for almost every aspect of program performance. With the assistance of funders, program staff could travel to their partner sites to learn from one another how their performance could be improved.

(5) Within a site, use techniques of continuous quality improvement and rapid improvement cycles.

(6) To make sure that services are culturally appropriate, home visitors should, at the very least, speak the primary languages of the families they serve, and handouts should be in the primary languages of the families. Of equal importance, home visitors should have a deep understanding of the culture of the families they visit, and, especially, of their beliefs about parenting, health practices, and the roles of women. To the extent possible, home visitors should involve members of the extended families of the mothers they visit.

3. Coordinate home visiting services and resources within each county.

Coordination should make home visiting services easier for families to access and less expensive to deliver.

a. Before launching a new home visiting program, county First 5 Commissions should sponsor a survey of existing home visiting programs.

Several counties (e.g., San Mateo, Orange, Los Angeles, and Riverside) have conducted surveys of home visiting programs in their counties. Such surveys can identify what home visiting models are in place, who they serve, their geographic cachement areas, how they get referrals to their programs, and the main goals of their services. This can identify geographic areas and families that are underserved, as well as opportunities for a more rational approach to referrals or service delivery. (See Box 6 for information about some of these surveys.)

b. Coordinate referrals to home visiting programs.

Within a county, different home visiting programs may excel at serving particular types of families or addressing particular goals. Counties may consider a centralized intake and referral system, such as the system that exists in Cuyahoga County in Ohio (See Appendix D), to assign families to home visiting agencies depending upon their initial needs.

In addition, county planning commissions should consider if it is possible to restrict the number of home visitors any one family might receive. Anecdotes abound concerning families who are being visited by five or ten home visitors – each from a different social service program. It is hard to see how this can be anything but a burden to families.

c. Coordinate messages across home visiting programs and across other service programs within the community.

Parents are faced with multiple messages about parenting and child development each day, beginning with what they hear from their own families and including what they learn from home visitors, child care providers, parent education workshops, and so on. The messages from any one program will be much more powerful if they are echoed in other programs. County First 5 Commissions should consider the possibility of supporting programs that adopt similar curricula across settings (e.g., a similar child development curriculum adopted by both a network of family child care homes and by a local home visiting program).

d. Require common definitions and terminology in reports on home visiting services from all county-funded agencies and organizations.

Common definitions will increase the ability of local commissions to make comparisons on program performance in subsequent years.

Box 6.
Planning for a Countywide Home Visiting Program:
Countywide Surveys

Some counties have commissioned surveys to describe all the home visiting programs operating within the county. These surveys vary, but typically are designed to determine where and under which administrative auspices the programs operate, their goals, and the families served. Such surveys can illuminate areas of redundancy as well as need, and opportunities for joint training, recruitment of families, and information sharing. Anecdotal reports continually surface of some families receiving visits from multiple home visitors, each with a slightly different focus. If communities could coordinate visits and the messages delivered to families, each intervention could become more powerful.

Orange County

O'Brien-Strain, M., & Gera, J. (August 16, 2001) *Home visitation programs in Orange County*. Available at www.sphereinstitute.org.

Researchers from the Burlingame, California SPHERE Institute surveyed home visiting programs in Orange County. The survey identified 17 home visiting programs, administered by 8 different agencies. The following information is captured for each program: Primary goals, home services, other services, target population, caseload per home visitor and annual caseload, staff credentials, scheduled duration and frequency of services, and the logic model for each program. The report also maps the outcomes hypothesized by the home visiting programs against the outcome indicators identified in the Orange County Children and Families Commission framework. The same researchers are undertaking a survey of Riverside County home visiting programs.

San Mateo County

Goodban, N. (2001). *Like a "segunda mama": Home visiting services for young children and their families in San Mateo County*. Report commissioned by the Peninsula Partnership for Children, Youth and Families. Available from the Peninsula Partnership web site (www.pcf.org) or by calling Peninsula Partnership at 650-358-9369.

This report includes a description of the 23 home visiting programs in operation in San Mateo County as well as results of structured interviews with program staff, focus groups with parents, and key informant interviews with local experts. Results are put into context with existing literature on home visiting. Best practices are identified and recommendations are made concerning access, best practices, service integration, and staffing.

The following information is listed for each program: mission, goals, target population, geographic area, year the program began, referral process, staffing/supervision, the program's theoretical or research justification, program components, collaborative partners, major challenges, performance measures, outcomes, evaluation, budget and funding sources, staff, new children/families annual, caseload, average/median time families spend in the program, number of home visits per month, desired and actual caseload.

As of February 2002, the study author reported that the recommendations were slated for review, prioritization, and, hopefully, implementation in coming months.

e. Coordinate the training of home visitors to save resources, build camaraderie, and help programs learn from one another.

Although each home visiting program has its own curriculum and will require some specific training, home visitors can all benefit from some core training about child development, parenting, family dynamics, the process of building

rapport with families, and so on. County First 5 Commissions could explore supporting joint training to help build the experience of home visitors and, perhaps, consolidate some of the expenses associated with training. In Sacramento County, for example, efforts are beginning to develop courses, perhaps in conjunction with community colleges, that will build a career path for home visitors. Just as in the child care field, such an effort might both develop the skills of home visitors as well as provide a path for their professional development – which could lead to lower rates of staff turnover.

4. Embed home visiting services in a system that employs multiple service strategies, focused both on parents and children.

Considerable evidence exists that, while parent involvement confers some unique advantages, such parent involvement does not lead to as large effects on children's cognitive development as do high-quality, center-based, child-focused services. In addition, home visiting is not the only route to achieve parent involvement. Therefore, program planners should:

a. Create a strong system of services that includes health insurance coverage, child-focused child development services, and home visiting, so as to improve parenting and promote child health and development.

Health insurance and access to health services. Home visiting programs often seek to make sure that children have a medical home or that they receive appropriate preventive health services, but randomized trials suggest that home-visited families usually do not show benefits over control groups. For families who have no health insurance, or who must take several buses to reach a doctor, even the best home visiting program's referral to a doctor will not translate into their children receiving appropriate health services. Communities should therefore focus on implementing the policies that will eliminate financial barriers to health care (e.g., health insurance) and/or consider the benefits of a close connection with a medical center or clinic. The Early Childhood Initiative in Cuyahoga County, Ohio (Appendix D) illustrates an initiative that encompasses a strong health insurance component that has successfully enrolled 98% of eligible birth- to 5-year-olds in health insurance. The Parent Child Home Program, administered by the Los Angeles Eisner Pediatric and Medical Center, is an example of a home visiting program that is administered by an agency that provides health care services. (Appendix C-6)

Center-based early childhood development. Home visiting services tend to focus on the parents and to encourage parents to change their behavior so as to create change in children. They deliver many fewer hours of contact with children than do center-based child care, preschool, or other early childhood programs. Together, these facts may help explain why home visiting programs more often produce benefits in outcomes related to parents and parenting behaviors than they do in outcomes associated with children.

Home visiting. Home visiting services or other services designed to increase parent involvement in their children's lives do confer benefits, and so they should be part of a community's system of services.

b. Include services that are focused both on parents and on children.

Many programs struggle to deliver child-focused child development services when parents have obvious needs for employment, social support, or material assistance. But, there is considerable evidence that programs achieve those goals on which they focus, and that children's development is not improved as much through a program in which the primary focus is on the parents as it is in a program in which the primary focus is on the child's own development.

Communities should therefore offer services that provide dedicated time and attention to both parents and their children. (See Appendix E (FAQ4): Should Programs Focus on Just a Few Goals or Should They Be Broad and Comprehensive?)

c. Offer multiple approaches for parent-focused services.

As many as 40% of those parents who are invited to enroll in home visiting services decline to participate. About half the families leave home visiting programs before services are scheduled to end. Those parents decline participation for a variety of reasons, but at least some of them might prefer a different service approach. Indeed, research suggests that programs that offer both home visits and parent groups attract somewhat different participants to each – and that parent groups can sometimes be more effective than home visiting.

Strategies other than home visiting that can be parent-focused include parent support groups, parent education workshops, Mommy and Me playgroups, and family resource centers. The goal within a community should be to increase the support afforded parents in their roles as parents – whether that support is derived through home visiting or some other service strategy.

d. Consult with families regularly to make sure that the mix of services is appropriate.

As in any business, client use of services reveals the clients' valuation of those services. Every home visiting program should solicit regular input from families to make sure that the service mix is balanced correctly, that families value the services offered, and that the reasons that families leave the programs are understood, and, if feasible, addressed. Programs should employ strategies, such as routine surveys, interviews, or focus groups with parents, to gather the opinions of the families they serve.

VII. CONCLUSIONS

Home visiting services can produce the results that prepare children for school, but they do not always do so in practice. And, benefits are often small. When averaged across program models, sites, and families, results for most outcomes are about .1 or .2 of a standard deviation in size, an effect size that is considered small in human services. Effects are most consistent for outcomes related to parenting, including the prevention of child abuse and neglect (depending upon how child maltreatment is measured). Home visiting programs do not generate consistent benefits in child development or in improving the course of mothers' lives. Families in which children have obvious risk factors (e.g., they are biologically at-risk, developmentally delayed, or they already have behavior problems) appear to benefit most. Some studies also suggest that the highest-risk mothers (e.g., low income teen mothers; mothers with poor coping skills, low IQs, and mental health problems) may benefit most, but probably only if the program offers services tailored to address the needs of these mothers.

For every outcome, as many as half of the studies and programs demonstrate extremely small or no benefits at all. But, for every outcome, a few programs or program sites demonstrate larger benefits, and it is those more positive results which have driven the expansion of home visiting programs and which illustrate the *potential* of home visiting.

The mixed and modest results, however, illustrate just how fragile an intervention home visiting can be. The most intensive national models are slated to bring about 100 hours of intervention into the lives of families. More typically, programs deliver perhaps 20 or 40 hours of intervention over the course of a few years. That is not much time in which to address issues as complex as child abuse and neglect, school readiness, and deferral of second pregnancies. But, that is the task that has been set for home visiting programs. It is therefore important for policymakers and practitioners to keep their expectations modest about what can be accomplished through any single intervention.

Nevertheless, high quality home visiting programs can play a part in helping prepare children for school and for life. Together with other services such as center-based early childhood education, joint parent-child activities, and parent groups, home visiting can produce meaningful benefits for children and families. For that reason, home visiting services should be embedded in a system that employs multiple service strategies, focused both on parents and children.

Even in such a system, the key to effectiveness is quality of services. Only the best home visiting programs have a chance to benefit children and parents, and funders and program administrators must strive to make each funded home visiting program a strong, high quality program.

To be effective, programs must focus on the goals that they seek to accomplish and make sure that their curricula match those goals, that their staffs are in sync with the

goals, and that the families they serve receive information and assistance related to those goals. Programs must seek to enroll, engage, and retain families with services delivered at an intensity level that is as close to the standards for their program model as possible. They should hire the best, most qualified staff they can, and pay them wages that will encourage them to stay. They should seek the counsel of their clients to make sure that they are offering services that their customers want and need. The good news is that quality is malleable, and that programs that set performance standards, monitor their progress toward achieving them, and make corrections along the way are much more likely to produce benefits.

Finally, funders and administrators should consider home visiting services from the point of view of parents and children. To that end, home visiting services should be coordinated within each community so that families receive referrals to the home visiting program that best meets their needs, home visiting programs share training and resources, and families are not faced with multiple visitors.

Home visiting services have the potential to build school readiness for children. They are best delivered as one of a range of community services offered to families with young children. They are not a silver bullet for all that ails families and children, but then no single program or services strategy can be. When done well, home visiting services recognize and honor the special role that parents play in shaping the lives of their children, and they can help create ready families and communities, ready children, and ready schools.

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